

IDAHO PROFESSIONAL APPLICATOR CERTIFICATE OF INSURANCE

The Idaho Pesticides Law and Rules Governing Pesticide Use and Application require that all applicants for an Idaho Professional Applicator License provide proof of financial responsibility before a license to apply pesticides will be issued. If, at any time, a licensed Professional Applicator fails to maintain financial responsibility, his license shall be automatically suspended [Idaho Code §22-3404(2)(e)]. Those Professional Applicators who choose to provide proof of financial responsibility by obtaining insurance for pesticide applications shall meet or exceed the minimum coverage requirements listed below. The insurance company, in all particulars shall complete this Certificate of Insurance form, and this original form shall be filed with the Idaho State Department of Agriculture.

1. Minimum Coverage Requirements:

- a. A minimum Bodily Injury coverage of **\$50,000** per person/**\$100,000** per occurrence and Property Damage coverage of **\$50,000** per occurrence.
- b. A maximum deductible of **\$5000**.

2. Type of Entity Providing Coverage: (i.e., insurance company licensed to do business in Idaho, surplus lines company, risk retention group)

- a. **Name of Insuring Entity** issuing coverage, and/or underwriters:
- b. **Policy Number:**
- c. **Name of Individual or Company Insured:**
Doing Business As (d.b.a.) (if applicable):
- d. **Address of Insured:**

3. Type of Insurance – Pesticide Application:

- a. **Limit of Liability Coverage for Bodily Injury:** _____ **Deductible:** _____
- b. **Limit of Liability Coverage for Property Damage:** _____ **Deductible:** _____
- c. **Policy Period:** From _____ To _____
- d. **Exclusions to Coverage: (List)** _____

4. Local Agent: Name _____ Phone _____

Address _____

5. **Policy Coverage:** This policy covers the individual or those employees of the insured, listed above in 2.c., who are engaged in pesticide use and application, pursuant to Title 22, Chapter 34, Idaho Code.
6. **Cancellation or Insurance Coverage Changes:** The insurance provider is requested to notify the Idaho State Department of Agriculture in writing of any change of coverage or cancellation of policy.
7. **Certification:** The above-described insurance policy has been issued by the named insurance company and is in full force and effect. I certify that I have legal authority to sign/act for _____ company (same as 2.a. above) and that said company is qualified to do business in the state of Idaho.

Signature of Authorized Agent

Date